COMMONWEALTH OF KENTUCKY
BOARD OF DENTISTRY

10101 LINN STATION RD, SUITE 540
LOUISVILLE, KENTUCKY 40223
PHONE: (502) 429-7280
FAX: (502) 429-7282

Authorization for Release of Medical and Dental Records to the Kentucky Board of Dentistry

I, _____ the undersigned, hereby
Print full name

authorizes the full release of any and all medical and dental records, billing information, and medical and dental reports from the dentist, physician, or other medical personnel, or any licensed health care facility regarding the medical and dental history, diagnosis, and treatment relevant to my initiating complaint, filed with the Board against

_____ to the Executive Director of the Kentucky
Name of dentist or dental hygienist

Board of Dentistry, or any authorized agent or investigator of the Board. The Board's address is: 10101 Linn Station Road, Suite 540, Louisville, Kentucky 40223. Copies of such documents may be mailed to the Executive Director at this address or hand-delivered to any authorized agent or investigator or the Board.

A photocopy of this authorization shall be deemed as effective as an original. This authorization shall be effective for one year from the date of signing.

_____ _____

Date **Signature of patient or legal guardian of patient**